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Surrogacy Policy in The United States and Germany: Comparing the Historical, Economic and Social Context of Two Opposing Policies

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Comparing the Historical, Economic and Social Context of Two Opposing Policies

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INTRODUCTION

"The machine does not isolate man from the great problems of nature but plunges him more deeply into them."

-Antoine de Saint-Exupery

Traditional surrogacy has been an alternative to traditional childbirth since biblical times. If a woman was unable to bear a child, her husband could have a child by another woman, with the intention of raising the child as that of his and his infertile wife's. However, before the success of artificial insemination in the 1970's, this practice still required the man to have intercourse with the intended surrogate, making traditional surrogacy a less than favorable option for most people. Today, with artificial insemination and *in vitro* fertilization (IVF) possible, technology enables a surrogate mother to gestate a child fertilized from another woman's egg, leading to the term "gestational surrogacy". What could be deemed a miracle of science however, has brought many ethical debates and legal problems to the surface. Here I find Antoine de Saint-Exupery's words ring all too true. With the technical possibility of traditional and gestational surrogacy, we are called to reflect on what we consider a family, who should be a family, what constitutes legal parenthood, what is acceptable to buy and sell, what can be signed away in contract, and how far our right to procreate extends.

As surrogacy calls into question so many fundamental issues, we are forced to look to our history, laws, and traditions in order to face the future with this technology. As a result, it is not surprising that no single resolution has been agreed upon. For example, in the United States, deregulation has been favored, allowing the

free-market to self regulate surrogacy and other assisted reproductive technologies (ARTs). In contrast, Germany has chosen to ban surrogacy completely under the broad scope of the 1991 Embryo Protection Act. These two otherwise similar countries, both very competitive in scientific and medical research, have reached very different conclusions on how to best balance the benefits and risks of surrogacy. The U.S. believes that the good of giving those otherwise unable the chance to have a family outweighs any drawbacks resulting from free market regulation alone. Germany believes that the harm of commodifying women and children, along with the eugenic implications outweighs any of the benefits.

Ultimately I argue that neither the U.S. nor Germany is correct in their mode of surrogacy regulation. I believe that a more moderate approach is preferable, where surrogacy is allowed but, highly regulated. I believe this model grants individuals unable to otherwise have children, freedom to reproduce, while still protecting parties left in harms way by the free market approach alone. In this thesis I will examine the practice of surrogacy and the ethical controversies that arise from the practice. I will then delve into the details of the policies or lack there of in the United States and Germany. Following, I will focus on the context of the differing policies and what has lead to their different stands on surrogacy. Specifically, I will look at the tradition of individual liberty in the U.S., the historical accounts leading to the preference of free market regulation, and the implications of the history of slavery. I will focus on the influence of Nazi practices on German reproductive policy, how this has lead to a political discourse focusing on the idea of a good society, and whether or not there have been signs of possible reproductive policy

moderation. I think it is very interesting how a society's economics and history can have such a huge effect on the ethical debate surrounding a technology. Finally, I propose my own policy for regulating surrogacy, in which I aim to minimize the possibilities of harm that are caused by surrogacy and surrogacy arrangements, while still granting reproductive freedom to those who require surrogacy to have a child. I hope this thesis makes apparent how complicated the ethical debate truly is, and demonstrates just how many aspects effect a countries ethical stance.

CHAPTER 1:

What is Surrogacy?

There are a number of reasons why someone would choose to have a child using surrogacy. A woman may be unable to conceive or carry a child due to a congenital uterine malformation or a previous hysterectomy. A woman may have suffered repeated miscarriages, or repeatedly failed to implant embryos using IVF. A woman may also have a severe medical condition, making pregnancy a serious risk to her own health (Nova 2011, *Gestational Surrogacy*). Same-sex couples also often utilize surrogacy to have children. Many female same-sex couples choose to fertilize the egg of one woman using artificial insemination, and have the embryo implanted into the other woman, so that both have a prenatal bond to the child. For male same-sex couples, a surrogate is needed to have a child genetically related to at least one of the men (Crockin and Jones 2010, 301). Surrogacy is not intended to be used for vanity's sake, in other words for women who would simply rather not gestate the child herself.

There are two types of surrogacy: traditional surrogacy and gestational surrogacy. In traditional surrogacy, the surrogate provides the egg and gestational role. Today, this requires the surrogate to be artificially inseminated by the intended father. No IVF is necessary. This means the child will be genetically related to the intended father and the surrogate, and not the intended mother. This procedure is typically simple and inexpensive (Nova 2011, *Gestational Surrogacy*). This type of surrogacy has a long history, going back to biblical times. The earliest reference to surrogacy is in the Old Testament (*Genesis 16.1-15*) when Sarai is unable to bear a

child, she tells her husband Abraham “go unto my maid Hagar; it may be that I may obtain children by her”. Ishmael is then born by Hagar to be Abraham and Sari’s son.

In gestational surrogacy, the surrogate carries a child that is genetically unrelated to her. There are many possibilities here. The intended mother can provide the egg, and the intended father the sperm, and the embryo is fertilized using IVF and implanted into the surrogate’s uterus. In this case, the child would be genetically related to both parents, but the mother would not carry the child or give birth. The intended parent(s) can also receive an egg from an egg donor, making the child unrelated to either the surrogate or the mother (if there is an intended mother), or can receive sperm from a sperm donor, making the child unrelated to the intended father (again, if there is an intended father). The intended parent(s) can even use an egg donor and sperm donor, and have the fertilized embryo implanted in a surrogated uterus. This would allow a parent or parents to have a child with no genetic relationship at all. Using surrogacy, people can go from the traditional 2 party involvement in reproduction up to a total of 5 parties involved. This still does not include the fertility doctors, or donor and surrogate agencies. Here we can begin to see how surrogacy can complicate reproduction and parental claims.

PROCEDURE

Gestational surrogacy is a complicated procedure for the women involved. Both the surrogate and the egg donor (whether the intended mother or a selected donor) must prepare for the embryo retrieval and transfer about a month in advance. Please keep in mind, hormone manipulation affects everyone differently

but can be emotionally and physically taxing. Daily injections are also painful and can be difficult to administer to oneself at the right times. Figure 1.1 shows a typical gestational surrogacy treatment sequence, though treatment does vary with individual cases.

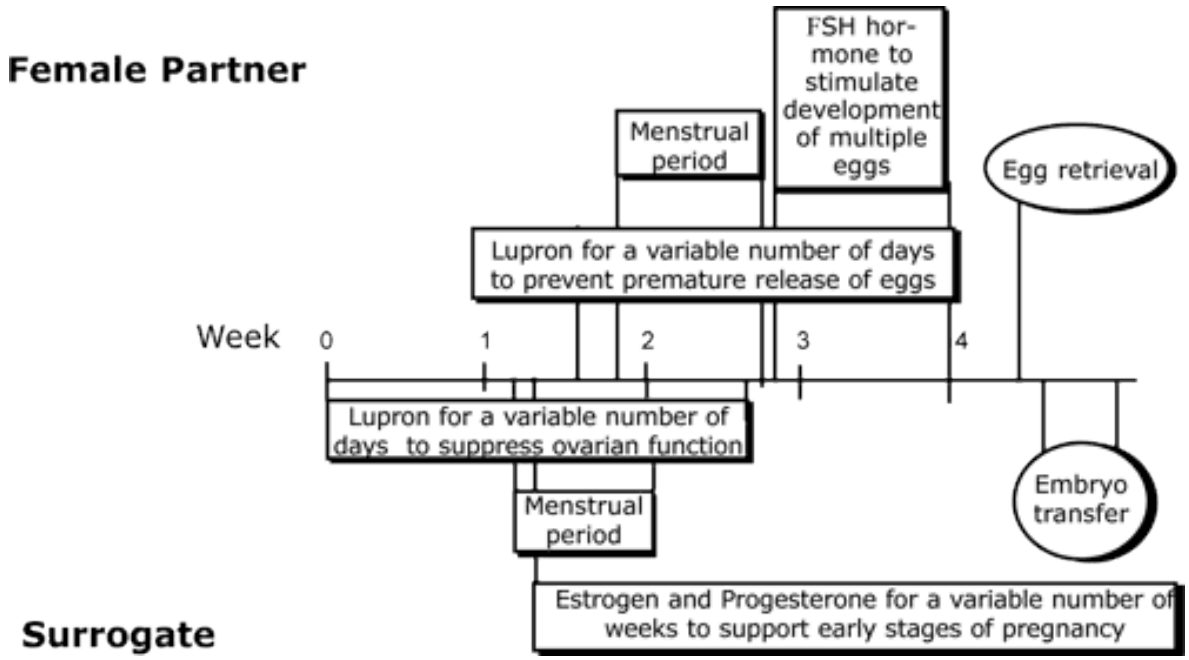


Fig. 1.1, Nova 2011,

Gestational Surrogacy

Beginning roughly 4 weeks prior to the embryo transfer, the surrogate begins GnRH agonist (Lupron®) administration. This is a daily injection for roughly two and a half weeks to suppress ovarian function in order to synchronize the two women's menstrual cycles. After about a week and a half, the surrogate begins to take estrogen and progesterone supplements, administered either vaginally, orally or through injection, to help support the early stages of pregnancy. This continues until the pregnancy test, and possibly several more weeks after pregnancy is established (Nova 2011, *Gestational Surrogacy*).

For the egg donor (whether the intended mother or not), the process may begin with oral contraceptives for cycles prior to the Assisted Reproductive Technology (ART) cycle. This helps regulate the menstrual cycle, ensuring that GnRH agonist is administered at the right time. Oral contraceptives may also help prevent ovarian cysts, which can develop during GnRH analogue therapy. About a week after the surrogate begins GnRH agonist administration, the egg donor begins the same GnRH agonist administration. For the egg donor, this is done primarily to prevent a premature LH (luteinizing hormone) surge, which could cause the eggs to be released before they are ready for retrieval. An ultrasound is performed around the time of the expected period to examine the ovaries and make sure there is no cyst. A blood test also ensures that the ovaries are suppressed (SART 2011, *ART: The Step-by-Step Guide*).

After menstrual bleeding begins, so does ovarian stimulation to support follicle development. There are many FSH (follicle stimulating hormone) medications available for this step, including Bravelle®, Repronex®, Lupron® and Gonal-F® to name a few (SART 2011, *ART: The Step-by-Step Guide*). Follicle development (egg development) is monitored using vaginal ultrasounds and blood tests, performed frequently to see if medication prescriptions need to be altered. After 7 to 12 days of ovarian stimulation, the egg donor is injected with human chorionic gonadotropin (hCG), a natural hormone that completes the maturation process of the oocytes. Timing is critical, as oocyte retrieval must be performed 34-36 hours after hCG administration (SART 2011, *ART: The Step-by-Step Guide*).

To retrieve the eggs, the egg donor is administered anesthesia as a transvaginal ultrasound probe guides a long needle into each follicle. The follicular fluid, oocytes, and granulosa (egg-supporting) cells are aspirated from the follicles (SART 2011, *ART: The Step-by-Step Guide*). The uterus, cervix and Fallopian tubes are never penetrated in the procedure (Nova 2011, *Gestational Surrogacy*). A physician collects the oocytes and follicular fluid in a test tube, and an embryologist locates the oocytes using a microscope. The egg donor is observed after the procedure as medication wears off. She will commonly feel lower abdominal discomfort and have some vaginal spotting for several days, but generally feels fully recovered in one to two days. Eight to 15 oocytes are typically retrieved per patient (SART 2011, *ART: The Step-by-Step Guide*).

In the embryology lab, eggs are then placed on a culture medium to support development of the embryo and mimic the environment of the fallopian tube or uterus. The dishes with eggs are placed in incubators to control the temperature and atmospheric gasses. Sperm are removed from semen collected either that morning from the intended genetic father or from frozen sperm, possibly from a sperm bank. After a few hours in the incubator, the sperm are placed in the culture medium with the eggs, and returned to the incubator to develop. Individual sperm can also be injected into each egg using the intracytoplasmic sperm injection (ICSI) technique. The next day, eggs are examined to make sure fertilization has begun. If so far successful, eggs will now be zygotes, a single cell with two nuclei. After five days, embryos should have developed into the blastocyst stage, where an embryo has 80 or more cells. Selection of the best embryos for transfer is based mostly on normal

visual appearance, though this does not guarantee a genetically "normal" embryo (SART 2011, *ART: The Step-by-Step Guide*).

The best appearing embryos are implanted into the surrogate's uterus using a thin embryo transfer catheter that passes through the surrogate's cervix to the top of the uterus. The number of embryos implanted depends on the surrogate and egg donor's ages, and on the appearance of the embryos. The more implanted, the more likely for a successful attachment, but also higher probability of multiple births. Excess embryos not transferred can be frozen (SART 2011, *ART: The Step-by-Step Guide*).

The surrogate begins to take progesterone supplements on the day or day after oocyte retrieval to help prepare the uterine lining for implantation. A pregnancy test is done 9 to 12 days after embryo transfer, and again a few days later if test is positive. If the second test is still positive, she continues with hormonal supplements and has frequent follow-ups with the fertility clinic. After 8 to 10 weeks of pregnancy, the surrogate can begin seeing a regular obstetrician.

The costs of surrogacy range depending on the number of treatment cycles needed, the cost of the donated egg, whether brokers or middlemen are used to find egg donors and surrogates, and the treatment costs of the independent clinic. The average price of a donated egg is $10,000, but can increase depending on the 'desirability' of the donor traits. The gestational surrogate also receives on average $10,000 to cover medical costs and discomfort. Lawyers are also needed to write contracts between the contracting parents and the surrogate, and between the two

intended parents. In total, a successful surrogacy treatment can cost from $80,000 up to $120,000 depending on how many treatment cycles are required (Saul 2009).

WHAT IS THE CONTROVERSY?

At first glance, it is not so obvious why there is such controversy surrounding surrogacy. With all parties entering into the arrangement freely, it seems as though everyone comes out a winner: the intended parent(s) can finally have a child and the surrogate can earn some money while bringing others happiness. However, the debate focuses on three central issues: the right to procreate, the exploitation of women and the enforceability of contracts.

The Right to Procreate

Some argue that to allow everyone the right to procreate, surrogacy is a necessity. They argue that women who are unable to bear children have the right to raise genetically related children, and need a surrogate to do so. Similarly, in heterosexual couples where the woman is infertile, the couple has the right to a child that is at least genetically related to the intended father, and a donor egg can be used for the genetic mother. Proponents argue that even when the child is unrelated to either intended parent, through surrogacy the parent(s) can take responsibility for the child before conception, as they would if they were having a child in the traditional manner. This is not possible in cases of adoption or foster care. The parent(s) can experience the "heightened intentionality" of pregnancy, though they themselves are not pregnant (Shanley 1995, 158).

Surrogacy is also an important technology for same-sex couples, particularly male same-sex couples. Male same-sex couples would be unable to have a child

genetically related to either man without the help of a surrogate. Many couples chose to have the sperm sample be a mixture from both men, so that the genetic father is random, possibly left unknown, and each feels like they made a genetic contribution. Though female same-sex couples do not need a surrogate to have a child, many take advantage of the technology by implanting the fertilized egg of one partner into the other, so that one woman is the birth mother and the other is the genetic mother. On the whole, surrogacy "would encourage a plurality of family forms in which parents would share a deep commitment to raising children" (Shanley 1995, 158).

Many legal issues also arise because more people are involved in the birth of a child. There have been cases of parentless babies, where neither intended parent is genetically related to the baby born to a gestational surrogate, and when the parents divorce, neither claims the child. Is the surrogate legally or morally responsible for the child then? In other cases, a gestational surrogate refuses to give the child to the intended parents after the child's birth because she does not believe the home is suited for children or that the parents will properly care for them. In these cases, who has the right to judge, and who has more of a claim to the children? In one case, a single man fathered a child using a traditional surrogate, and killed the child shortly after its birth. This case raises the question of whom do fertility clinics need to serve and how necessary are psychological screenings? This also raises the issue of commodifying children, because with the help of fertility clinics and various egg, sperm and surrogacy brokers, a child can, to some extent, be manufactured and bought. How harmful is commodifying children and to whom exactly?

Some opponents to surrogacy do not see the opportunity to procreate as a positive right. This means that no one can be prevented from having children, but they do not need to be helped to have children at any cost. For those who would require surrogacy, adopting a child is seen as a moral alternative. This would allow the parent(s) to raise a child as if it were their own. After all, there are children without families all around the world. However, there are still issues with adoption as the sole alternative. The adoption process is very complex, and it can take years to arrange a successful private adoption, where the adopting parents would have the child very shortly after it is born. Secondly, many same-sex couples are actually prohibited from adopting a child because of the agencies' prejudiced regulations. Thirdly, because there is a shortage of white babies for adoption, real prejudices or honest inability could prevent parents from raising children of color, older children or children with disabilities to the best of their ability. Though this can be blamed on the parents' prejudices, society also makes it very difficult for families with children of color or with disabilities (Narayan 1995, 187). This is, of course, a very complex and multifaceted issue on its own, so I have chosen not to further elaborate on adoption as an alternative to surrogacy.

Contracts

The arguments for and against surrogacy tie the enforceability of contracts and the objectification of women together. This is a very important issue because the only way surrogacy is really regulated in the U.S. is through individual contracts. These contracts are between the surrogate and the intended parents, generally stating that the surrogate will renounce her parental claims once she gives birth.

Thus, the contractors will become the child's legal parents. Those in favor of enforceable surrogacy contracts are largely on the side of the contracting parents, who hope to see their emotional and financial investment protected. If the contract were not enforceable, there is the danger of the surrogate keeping the child, even if it is not genetically hers. This would be easy because most states assume the birth mother to be the legal parent.

There are feminist arguments for the enforceability of surrogacy contracts as well, focusing on the rights and autonomy of the surrogate. They argue that women have the right to enter a contract to receive money for the service of bearing a child. Contract pregnancy shows that child bearing and child rearing are separable, and that a woman's childbearing ability does not define her socially or legally as a "mother". If a woman is not expected to uphold a contract she enters freely, then she is perceived as legally incompetent and unable to act rationally regarding reproduction. This would reinforce social stereotypes that women are less rational than men, and that they are ruled by instinct and sentiment. Proponents believe that contract surrogacy is an expression of a woman's freedom to undertake any form of work she chooses. The surrogate is not receiving money for the child, but for the labor, like any other form of labor, of gestating the fetus. This allows the woman full ownership of her body and capabilities. Allowing men to contract pregnancies also encourages a more gender-neutral delegation of parenting responsibilities (Shanley 1995).

There are also many feminist arguments against the enforceability of surrogacy contracts. These focus on the differences between surrogacy and other

types of productive work. With traditional surrogacy, it is not just the surrogate's labor being sold, but her genetic material as well. Here, a price is put on the woman's personal attributes such as race and IQ, and on her reproductive capacities. This feeds the problem of commodifying women and women's bodies. Though with gestational surrogacy the woman is not selling her genetic material, her physical and psychological self are much more involved in gestation than in other forms of labor, and a human, not an inanimate product is produced. Contract pregnancy is seen as self-alienation because it forces the woman to remove herself from her womb and fetus, and disassociate herself from her body and her reproductive capacities. Women are often led into surrogacy out of desperation, and enforcing the contracts exploits their economic need. The contracts allow capitalism to enter into a new sphere where it turns women's labor into a commercial production process. By forcing the surrogate to suppress her emotional ties to the child, she is alienating herself from her labor. She belittles her self-worth in the contract pregnancy, as is common, though to a lesser extreme, in many other labor contracts (Shanley 1995).

Opponents say contracts cannot be enforced because the mother and fetus have a different relationship at the time of the birth than at the time the contract is signed. Mary Shanley compares this to our view of divorce. Though marriage is technically a life long contract, the contract is broken through divorce because we recognize that "the law cannot permit people to be bound to a promise when they and their relationship have fundamentally changed" (Shanley 1995, 166). With contract pregnancy, the relationship has changed even more so than it could during

divorce. When the woman enters the contract the fetus does not even exist, and when she gives birth, the surrogate herself has changed and formed a nine-month physical and emotional relationship with the fetus. The right to enter such a contract is compared to the right to enter a slavery contract; in both cases the woman forgoes future use of liberty beyond one single free act of abdicating her liberty (Shanley 1995, 165).

Many of these issues are commonly seen as issues of commercial surrogacy, because economic need prevents women from acting freely. Uma Narayan believes that even without direct payment for surrogacy (so called Gift Surrogacy), forces of patriarchy still prevent women from making free decisions. If a woman agrees to be a gestational surrogate without economic compensation, she is usually doing so for a family member or friend. In these situations she can be exploited based on her economic dependency to the contractors, and pressured emotionally by those close to her. Gift surrogacy assumes the gender-roles that women are self-sacrificing and altruistic. It also reinforces the ideas of women's economic powerlessness, where their domestic duties and childbearing abilities are "gifts of love" not of real value (Narayan 1995, 182).

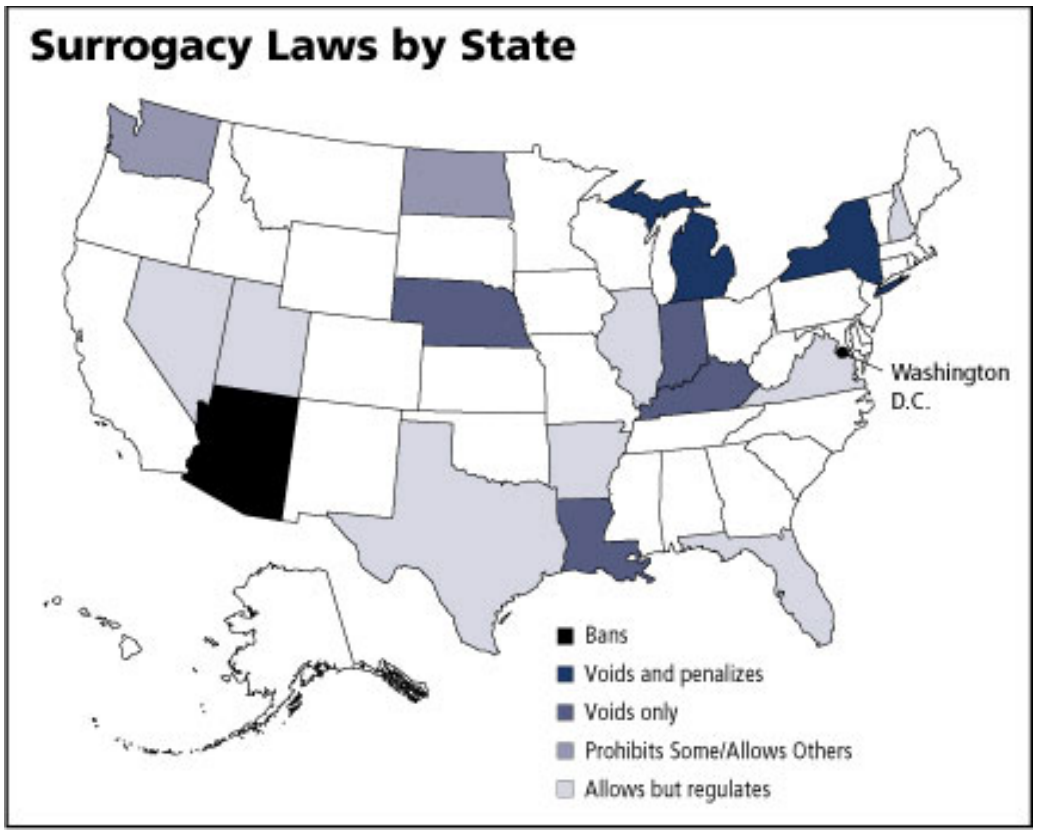
Here we begin to see just how complex and multifaceted are the issues surrounding surrogacy. Surrogacy can either empower or exploit women's bodies. Enforcing contracts can either infringe on or promote women's autonomy and self-determination. Commercial and gift surrogacy can abuse women's economic dependency. Both the contracting parents and the surrogate have rights to be

protected. It is clear that there is no simple answer as to how to regulate surrogacy and protect all of the parties involved. The United States and Germany are two examples of nations taking opposing stands, each trying to protect what they see as most important.

CHAPTER 2:

Surrogacy Regulation in the United States

Roughly 750 babies are born each year in the Unites States using surrogacy, and nearly twice as many surrogacy pregnancies are pursued. In the U.S. however, surrogacy standards and contracts are left largely unregulated. Fertility doctors are left to their own devices for the most part, deciding who is eligible to receive surrogacy services or become a surrogate, and to what extent they will follow guidelines set by the American Society for Reproductive Medicine. With no national legislation, and a rise in custody battles and other legal disputes, it has been left to the states to regulate surrogacy (Saul 2009). Still, only 18 states have any surrogacy laws. Below is a chart of states' various surrogacy regulations.



(Center for American Progress 2007)

STATE BY STATE

State surrogacy laws range from total bans on surrogacy to regulations aimed to protect the intended parents or the surrogates. The range of laws can be very confusing and often lead to disputes between states with conflicting laws when surrogacy arrangements cross state lines. Both Arizona and the District of Columbia prohibit all surrogacy contracts, rendering any made unenforceable. This makes the surrogate mother the legal mother. In D.C., violators can be punished with a fine of $10,000 or a year in jail. New York and Michigan find surrogacy contracts to be contrary to public policy and thus void and unenforceable. This means in any custody dispute between a surrogate and the intended parents, custody would be given to the birth mother, the surrogate. In Michigan, parties to the contract can be charged with a misdemeanor, and parties who induce and arrange the contracts can be charged with a felony, punishable with a fine of $50,000 or five years in jail. (Center for American Progress 2007)

In Indiana and Nebraska, all surrogacy contracts are void and unenforceable. This differs from Michigan and New York laws only in that surrogacy contracts are not criminalized, meaning participation in a contract could not be held against someone if a custody dispute arises. In Nebraska, the biological father assumes custody of the child. Kentucky and Louisiana hold traditional surrogacy contracts, in which the surrogate is the biological mother, to be void and unenforceable. However, these two states have no laws regarding gestational surrogacy, where the surrogate is not genetically related to the fetus. In North Dakota, traditional surrogacy contracts are also void, making the biological mother the legal mother.

However, gestational surrogacy contracts are recognized, making the intended parents the legal parents. In Washington, surrogacy contracts are enforceable, but if there is compensation beyond medical expense, or if the surrogate is a minor or suffers from a mental illness or disease, then contracts are void and unenforceable (Center for American Progress 2007).

Surrogacy is allowed but regulated to varying degrees in Arkansas, Florida, Illinois, Nevada, New Hampshire, Texas, Utah and Virginia. Some of the states protect unmarried couples and single people in surrogacy contracts just as married couples, and other states require couples to be married for contracts to be valid. Some states require at least one of the intended parents to have a genetic link to the child, either through using his sperm or her egg for the fetus. Nevada requires gametes from both intended parents. Some require the intended mother to prove that she is unable to either gestate or birth the child, making a surrogacy arrangement necessary. Some states prohibit traditional surrogacy, where Florida treats it as a "preplanned adoption agreement", giving the mother 48 hours after the birth of the child to change her mind and the adoption must be approved by the courts. Compensation is either prohibited or restricted. In Utah the surrogate must not be receiving Medicaid or other state financial services. Surrogacy contracts must be judicially preauthorized in some of the states, requiring medical and/or psychological evaluation of the intended parents and the surrogate, home studies, independent legal consultation, proof that the surrogate has given birth before, and that the surrogate is of legal age (Center for American Progress 2007).

LEGAL DISPUTES

Not only are there disparities in the states' surrogacy laws, but there is no regulatory system to make sure that fertility clinics, brokers and lawyers actually follow the laws. Not until an issue is taken to court are these laws enforced. Many laws are also made in court as the issues arise. Such is the case with one of the first court rulings of surrogacy, in the New Jersey case of "Baby M" in 1986. William and Elizabeth Stern commissioned Mary Beth Whitehead to be a traditional surrogate. Ms. Whitehead was inseminated with Mr. Stern's sperm, and she was supposed to carry the child to term, and relinquish custody of the child to Ms. Stern when the child was born. After the birth however, Ms. Whitehead decided to keep the child, and Mr. and Ms. Stern sued to gain legal parental right, as stated in their contract. The New Jersey court ruled in favor of Ms. Whitehead as the child's legal mother, invalidating any contract that would force a mother to give up her biological child. Mr. Stern, as the biological father, was awarded legal custody of the child because it was seen to be in the best interest of the child, and Ms. Whitehead was granted visitation rights. (Crockin and Jones 2010)

Numerous cases show what can result from fertility clinics failure to follow surrogacy guidelines, including psychological screenings of surrogates and intended parents, requiring the surrogate to have previously given birth, making surrogacy contracts in states where they are unenforceable, and problems when surrogacy and adoption cross state lines. In the case of Amy Kehoe, from Grand Rapids Michigan, Mrs. Kehoe used the Internet to arrange to have a child using surrogacy. She found an egg-donor, a pre-med student at the University of Michigan through an egg-

donors database, an anonymous sperm donor on the California Cryobank website and a gestational carrier, Laschell Baker from Ypsilanti Michigan, on surromomsonline.com. Laschell was a mother of four, married to Paul Baker, and had delivered three other surrogate babies, all without a glitch. She suggested IVF Michigan to Mrs. Kehoe as their fertility clinic because she had a good history with them. After twins Ethan and Bridget were born, Mr. and Mrs. Kehoe took their new babies home (Saul 2009).

One month later though, custody was awarded to Mrs. Baker, the gestational carrier with no biological relationship to the children, because Mrs. Baker discovered that Mrs. Kehoe was being treated for psychotic paranoid schizophrenia. Mrs. Baker feared that Mrs. Kehoe could relapse at some point and would not be a good mother. Because Michigan does not validate surrogacy contracts, seeing them as contrary to public policy, even though Mrs. Baker was not the biological mother, neither was Mrs. Kehoe, so Mrs. Baker as the birth mother was awarded legal parentage. Mrs. Baker regrets that IVF Michigan did not perform the recommended psychological screening on Mr. and Mrs. Kehoe before allowing them to commission the twins' birth. Mrs. Baker said she regrets that she was put in such a difficult situation, but felt it necessary to reclaim the twins. The surrogacy community has lashed back at her for staining their reputation, but Mrs. Baker believes it all could have been avoided if there had been a psychological screening (Saul 2009).

In another case, Stephen Melinger, a 58 year old single elementary school teacher in Union City, NJ, commissioned the birth of two twin girls using a gestational surrogate in Indianapolis and an egg donor. The twins were born

premature on April 8, 2005. When Mr. Melinger visited them in the hospital, the staff was concerned about his ability to care for the girls, because he came in holding his pet bird on one occasion, and had bird feces on his clothing. He also had planned to drive the tiny babies 12 hours home to NJ, by himself, with the girls in car seats. He was still able to adopt the twins, though there was concern. His lawyer classified the twins as 'hard to place' children, because their mother was African American, making the girls half black. This was just the first lie. Though the gestational surrogate was African American, the egg donor was white. Mr. Melinger had also claimed to be the sperm donor, however, a paternity test proved that he was not biologically related to the girls. He also said he was born in Indiana, when he was, in fact, born in New York.

The girls were soon put into foster care because Mr. Melinger had intentionally deceived the courts and the hospital had filed reports about his behavior. He was able to successfully adopt the girls again in 2006. At home in New Jersey, child welfare was called to investigate Mr. Melinger because the girls were seen dressed improperly for the cold winter and their doctor worried about their care. The caseworker saw that the home was very dirty, smelled of urine, and that the girls did not have proper clean clothes. They were again placed in foster care, but returned to Mr. Melinger when he was defended in court. The case continued however, because the state of Indiana, the girls' birth place, wanted the adoption to be repeated. The adoption was incomplete the first time, due to a missing a letter from NJ stating that placement of the girls with Mr. Melinger in NJ was in the girls best interest (Saul 2009). In this case, we again see the issues when there is no

psychological screening for intended parents. There are also complications of arrangements that cross state lines, because each state has different laws. Among all the confusion and lack of regulation, lies like those of Mr. Melinger can fall through the cracks. If the hospital's worries had not started an investigation, the courts may never have learned about all of Mr. Melinger's deceit. Sadly, it is the twins who suffer from the shortcomings, going in and out of foster care.

In the case of Mr. Robinson, he and his husband Mr. Hollingsworth commissioned the birth of twins using Ms. Robinson, Mr. Robinson's sister as a surrogate and Mr. Hollingsworth's sperm. They had hoped to have Ms. Robinson as a traditional surrogate, making the children genetically related to both men, but she had no viable eggs, so a donor egg was used instead. Usually fertility clinics require surrogates to have previously given birth to ensure fewer medical complications, and so the surrogate understands the biological and emotional implications of pregnancy and birth. However, because Ms. Robinson was Mr. Robinson's sister, and had no personal interest in having children, they waived that requirement for her. She also chose to waive the psychological screening. The pregnancy and birth proved to be very difficult, with Ms. Robinson hospitalized for pre-eclampsia. The twins were nevertheless born healthy, and went home with Mr. Robinson and Mr. Hollingsworth in New Jersey. After five months, Ms. Robinson filed for custody of the twins, citing the 'Baby M' case as principle. In this case however, Ms. Robinson had no genetic relationship to the children, whereas Mrs. Whitehead , in the case of Baby M, was the biological mother. Ms. Robinson claimed that though she was paid $10,000 for her service, there are some things that money should not be able to buy.

Until the trial, Ms. Robinson was temporarily awarded custody for 3 days each week, making the twins shuttle between the two New Jersey homes (Saul 2009).

This is another case where the fertility clinic failed to adhere to guidelines, which were set for a reason. The clinics do not suffer any consequences for their actions because they are merely guidelines, and there is no true regulatory system. Fertility clinics decide how they want to conduct business on their own, and what they consider to be ethical. They also profit from carrying out surrogacy arrangements. It would not be in their financial interest to turn a couple down after a poor psychological screening, especially since that same couple could then be approved by a competing clinic. Surrogacy can cost couples from $80,000 to $120,000, including the various broker, legal and medical expenses, and surrogate fees (Saul 2009).

At such a cost, the intended parents need protection by being informed of the applicable state laws. They should not be led to assume a contract guarantees them a child in states like Michigan where surrogacy contracts are unenforceable, as in the cases of the Kehoes and Mr. Robinson. Surrogates also need protection, a way to know that they are not putting a child in dangerous hands. Mrs. Baker would not have gone through with the pregnancy knowing that Mrs. Kehoe was being treated for mental illness. The potential children also need protection, because they are brought into the world without a choice, and should not be purposefully placed in unfit hands like those of Mr. Melinger. The American Bar association has created a model act for legislation intended to guide judges in the complicated legal cases involving reproductive technology. One suggestion is in cases where the intended

parents have no genetic link to the child, the surrogacy arrangements should require preapproval by the court including a home study. Though these only make up five percent of surrogacy cases, they are legally the most complicated. Some people argue that because a psychological screening and home study are not required in traditional reproduction, it is unfair to require one when surrogacy is involved. I believe that no one can be stopped from reproducing. On the other hand, just because someone commissioned and paid for conception, no child should be placed blindly into a home. When there is no genetic link, there is very little difference between surrogacy and adoption. This is the point at which I disagree with the conception of reproduction as a positive right. Though no one can be denied their ability to procreate, people should not be guaranteed a child just because they can pay for it.

CHAPTER 3:

Germany's Embryo Protection Act

The United States marks one end of the reproductive technology regulatory spectrum, with its minimal regulation. Germany is at the opposite end of the spectrum, highly regulating reproductive technologies and completely banning traditional and gestational surrogacy. Germany's laws were passed by the Bundesrat and Bundestag, the two German parliaments, and set into force on January 1st, 1991 in The Embryo Protection Act. In the 1980's, controversy over the status of embryos used in IVF arose and the creation of embryos for research purposes became an intense debate. Though The National Chamber of Doctors issued guidelines for embryo research to prevent legislation, the guidelines were viewed as too lenient. Radical Greens, feminists and conservatives "rallied behind the call for the state to protect embryos from abuse, instrumentalization, and destruction" (Robertson 2004, 7). As a result, The Embryo Protection Act protects embryos as the initial form of human life.

According to German law, embryos deserve protection based on three fundamental rights stated in the German federal constitution. These are the protection of human dignity, the demand to guarantee free development of personality, and the right to life (Hashiloni-Dolev and Weiner 2008). Germany grants embryos the same positive constitutional right to life and dignity as all people. The Embryo Protection Act defines embryos at the point of syngamy. This means protection is granted to "the human egg cell, fertilized and capable of developing, from the time of fusion to the nuclei" (Federal Law Gazette 1990).

Nuclear fusion occurs about twenty hours after insemination. This still leaves zygotes and pronuclear embryos before syngamy unprotected.

According to The Embryo Protection Act, it is punishable with up to three years imprisonment or a fine to use donor eggs, to transfer more than three embryos into a woman in one treatment cycle, to fertilize more eggs than can be transferred into a woman in one treatment cycle, or to utilize traditional or gestational surrogacy. Likewise, it is illegal to create embryos "without intending to bring about a pregnancy in the woman from whom the egg cell originated" (Federal Law Gazette 1990). The Act also states that only a physician may carry out the permitted ART procedures. These laws prevent the freezing of embryos, so fertility doctors freeze inseminated eggs before syngamy occurs. This is because German fertility doctors, much like those in the U.S., but to a lesser extent, hyperstimulate women to produce multiple eggs. These eggs are then inseminated or injected with a sperm ("ICSI"). Only three can be transferred to the uterus in a single cycle. This limitation may cause a lower success rate of pregnancy per IVF transfer, but also reduces the rate of multiple gestations (twins, triplets and quadruplets). By criminalizing egg donation and surrogacy, these laws also prevent women who cannot produce viable eggs, or cannot gestate or give birth, from having a child. There is, however, no clear explanation as to why male gamete donation is allowed, but not female's. The law also prohibits the creation of embryos for research. This has left Germany behind in Embryonic Stem Cell research, despite Germany's history of distinguished biological and medical research and development (Robertson 2004).

The Embryo Protection Act further regulates reproductive technologies in areas of ethical dispute. The Act bans sex selection for non-medical reasons. Selecting sperm for insemination based on sex chromosome is only allowed to prevent severe sex-linked genetic illnesses such as Duchenne-type muscular dystrophy. This inhibits the future possibility of selection based on traits such as hair or eye color. The Act requires a woman's consent for her egg cell to be fertilized, and a man's consent for his sperm cell to be used in fertilization. Further, the Act criminalizes posthumous IVF, stating that a man's sperm may not be knowingly used after his death (Federal Law Gazette 1990).

It is punishable with up to five years in prison or a fine to artificially alter genetic information of a human germ line, or use genetically altered human germ cells for fertilization (Federal Law Gazette 1990). The ethics of genetically engineering future children is of great debate as scientists try to develop the technology. Proponents say that it could help reduce illness, prolong lives and make people happier. Opponents fear genetic engineering could make us lose aspects of human nature and commodify children. Like many critics of genetic engineering and trait-based selection, Germany recognizes these techniques as a new eugenics, which Germany wants to avoid completely. However, to prevent Germany from falling behind the rest of the world in terms of biological and medical research, artificial alterations of germ cell's genetic information is allowed if it is outside the body, and its use for fertilization is ruled out.

The Embryo Protection Act criminalizes any attempts at cloning with up to five years imprisonment or a fine. The same punishment is for anyone who attempts

to create chimaerae or hybrids. This means that human embryos or sperm may not be fertilized with or by (respectively) genetic material from an animal. Likewise, a human embryo may not be transferred into an animal (Federal Law Gazette 1990). These are further examples of Germany's policy to avoid a certain future, rather than wait to react to scientific development, at which point intervention through legislation may be too late.

The Embryo Protection Act extends much further than surrogacy, but I shall refocus on the issue. By criminalizing both traditional and gestational surrogacy, women who suffer from infertility, or are otherwise medically unable to carry or deliver a child, suffer the consequences. Male same-sex couples are also unable to have a genetically related child. Though the laws are intended to protect the embryo and future child from commodification, and protect egg donors and surrogates from financial coercion and further commodification of women's bodies, infertile women have no protection here. There is also no clear reason why sperm donation is acceptable, but egg donation is not. The child results from the genetic information of both gametes. The only real distinction is the much more intrusive extraction of female gametes than male gamete. Can a medical procedure really carry such moral weight? I believe it is possible to avoid the myriad of lawsuits and custody battles as seen in the U.S., limit the financial coercion of surrogates and egg donors, and minimize the commodification of both children and women's bodies without criminalizing surrogacy. However, because the groups of people left out by this law are in the minority, there is less pressure for legal change.

CHAPTER 4:

Context of U.S. Surrogacy Policy

As discussed in chapter 2, the United States has no national policies regulating surrogacy, or other assisted reproduction technologies for that matter. This is in stark contrast to Germany, where surrogacy is prohibited and ARTs are regulated under the Embryo Protection Act. I will argue that law, economics and history have formed the contexts leading the two otherwise similar countries to take such different stands on surrogacy. In the United States, family law is left to the individual states to regulate, causing the disparity in surrogacy regulation between the states. A tradition of individual liberty and free market economics cause Americans to avoid unnecessary government interference. The history of slavery is conjured up when reproduction is recognized as a commercial transaction, but prohibition in reproductive technologies has proven unproductive in the cases of contraceptives and IVF. The long-standing liberal tradition in America, idealizing independence and liberalization, also supports the right of people to form families in whatever form they please without big-government involvement. With the rights of the parents protected by the free market though, are the rights of other parties involved, namely surrogates, egg donors and children, overlooked? It is not impossible for the U.S. to protect the rights of the parents while simultaneously preventing exploitation of others with some regulation in surrogacy.

STATE LAWS

In the United States, court cases involving family law (*i.e.* parental status, rights, obligations, etc.) are determined by the individual states. No individual state

must agree with or follow the rulings of another state. Until heard at the highest level of state court, all decisions hold limited value as precedent (a ruling that must be followed) within that state, and court decisions from one state are not precedent in another state. However, in cases involving ARTs, state courts often look at rulings from other states for guidance in making their own ruling. This is because of the complexity of the cases, as discussed earlier, and the lack of precedents already set. Under the "full faith and credit" clause of the U.S. Constitution, state courts are required to recognize and uphold decisions made by a court in another state when brought before them. The only exception to this is the federal Defense of Marriage Act (DOMA), which allows a state to discredit a marriage from another state if it violates public policy. New laws are heavily influenced by older, more established areas of law. This means that legal issues in ARTs call "family, health, contract, discrimination, tort (civil wrongs, such as negligence and malpractice), and constitutional law… into play" (Crockin and Jones 2010, 12). The differing state laws in all of these areas complicate legal surrogacy disputes when arrangements cross state borders. In these cases, states must interpret the laws of other states. Federal courts must also follow and uphold state laws.

Although complications arise from the differing laws and lack of federal regulation in surrogacy, America has a "long tradition of individual liberty, free market and free enterprise orientation, and grants of wide autonomy to physicians and other professionals" (Robertson 2010, 3). Religious liberty is also highly valued, and religious ideals do influence public policy. In response, the U.S. separates the public and private spheres, with reproductive technologies as a perfect example.

Abortion, contraception, assisted reproduction and embryo research are all legal, but states are not federally required to fund them. This prevents too much intrusion of the government into personal affairs. The American people have shown that they do not want the federal government controlling something as personal and individual as reproduction. For example, in Roe v. Wade and Casey, the individual states are left to decide how protective of the fetus they want to be without imposing "undue burdens" on a woman's pre-viability abortion choice. As a result most states have imposed waiting periods and mandatory counseling in order to have an abortion on demand during the first trimester. In the 1980s, Maher v. Roe and Harris v. McCrae "denied a positive right to state funding of abortion", again leaving the individual states and private insurers to decide whether to provide funding (Robertson 2010, 6).

It is not always easy for states to pass legislation in areas as sensitive and private as reproduction. For example, in 1992, California attempted to enact the first law in the U.S. to comprehensively legislate commercial surrogacy. The law would require surrogates to be at least twenty one years old, have had a previous child, and receive counseling before and after giving birth. Payment of the surrogate would be capped at $15,000. The law would also distinguish between traditional surrogacy, where the surrogate could change her mind after birth and share custody with the genetic father and the intended parents would need to adopt the child, and gestational surrogacy, where the surrogate could not change her mind and the children would automatically be under the custody of the genetic parents. The bill was sponsored by the Beverly Hills based Center for Surrogate Parenting because of

the flourishing business of surrogacy in California above other states. However, the legislation was vetoed by California governor Pete Wilson for reasons unclear (Crockin and Jones 2010).

According to Louis Hartz in *The Liberal Tradition in America*, American history and politics have followed an "American Way" founded in the liberal traditions of "individual liberty, equality, and capitalism… [regarding] the human marketplace, where a person succeeds or fails by his or her own efforts and ability, as the proper testing ground of achievement" (Wicker 1991, ix). Hartz attributes the American dedication to the protection and cultivation of the individual against the powers of the state to the absence of a feudal history. Tocqueville noted this phenomenon, stating that, "The great advantage of the American is, that they have arrived at a state of democracy without having to endure a democratic revolution; and that they are born equal, instead of becoming so" (Wicker 1991, x). This means that unlike in Europe, where people had to fight for democracy through revolution to end feudalism and bring equality to people, America was founded already assuming all people were equal. Hartz believes that because liberalism is a natural phenomenon in the U.S., the American people lack the revolutionary tradition and are indifferent to the challenges of radical politics such as socialism and communism. This is because if all people are born equal, they do not recognize any obligation of the state to ensure and promote their equality. I believe that this explains why, in America, surrogacy is left to the free market to promote freedom and equality, whereas in Germany, social inequalities are recognized, so the state uses regulation to foster freedom and equality.

THE FREE MARKET

Largely unregulated, surrogacy, as well as other ARTs, is left up to the free market. This has led to the term, "baby markets". According to Michele Goodwin, "deregulation is a key factor in free market economics" (Goodwin 2010, 5). Other evidence that surrogacy is a part of the free market includes financial incentives for clinics, payments to the surrogates and donors, exorbitant fees to agencies, and value based on genetic preferences with gamete donors.

The free market self regulates by supply meeting the demand. This is just what happened with surrogacy in 1976 when Noel Keane, a Michigan attorney, was approached by multiple clients interested in having a child using a surrogate because of the recent success of artificial insemination. Keane then took on the roll of broker, and began advertising to find potential surrogates, in other words, the supply to meet the demand. In Michigan however, it is illegal to sell babies, and because surrogacy was still limited to traditional surrogacy, receiving payment would constitute the surrogate selling her biological child to the contracting parents. Keane then attempted to advertise for gift surrogates, who would receive no payment for their services. As is typical in the free market, without any financial compensation, the supply of surrogates vanished (Spar 2005).

IVF

There was a lot of controversy around surrogacy, with opponents criticizing the commodification of women and children and proponents looking at parental desperation and the right to contract. Still, the market for surrogacy was small. Economically this makes sense because there was still so much uncertainty in the

market. There was no legislation guaranteeing the legal rights of the contracting parents, and it was still ethically uncertain what was actually being bought. Hopeful parents were unclear whether they were paying for the child, for the surrogate's genes or for her labor. Then in 1978, Louise Brown, the result of IVF, was born in England. Initially IVF was used within the legal bounds of marriage for women with defective fallopian tubes. Once IVF was possible however, the sacred bond of womb and eggs was broken. A woman could now gestate a child that was not her biological child. Legally, receiving payment for surrogacy would no longer have to constitute selling a child, because a gestational surrogate would carry a genetically unrelated embryo. The payment was more clearly for the gestation, not the child itself. This was also attractive to parents because with gestational surrogacy, the surrogate had less of a bond to the child, so the contracting parents had a stronger legal claim to the child. (Spar 2005)

IVF was clearly a breakthrough for surrogacy causing both supply and demand to soar. In 1995, the New York Columbia-Presbyterian Medical Center had only 5 egg donors on file. By 1998, there were 500 on file with 50-100 calls per week from women interested in becoming egg donors. This surge in supply was because more women were interested in taking on the role of just egg donor, not surrogate, or just surrogate not egg donor. With women receiving on average $2,500 for an egg donation, and more for eggs from women with very desirable traits, and gestational surrogates receiving $10,000 per pregnancy, both options were extremely enticing. Demand also increased as parents felt they had more options with gestational rather than traditional surrogacy. The egg and womb were no

longer bundled together in one package. Contracting parents could choose the right egg donor and the appropriate gestational surrogate, and even a sperm donor. They no longer felt they were buying the surrogate's child, and they could have a stronger legal claim to the child than the surrogate (Spar 2005).

The baby market, however, is different from other commercial markets. In the baby market, demand is virtually limitless. Hopeful parents have proven that they will go to outrageous lengths to have a child. There is little price incentive to parents hoping to have a child through surrogacy. If they want a child, and want to use a surrogate, they will pay for it. This explains why, as the supply of egg donors and surrogates rose, prices did not decrease. Usually, as supply increases, prices go down in order to further increase the demand. However, because of the extraordinary demand, prices have not gone down. This is also caused by the lack of suitable substitute products. There is no downward price pressure created by substitutes in another market. As Kimberly Krawiec puts it, "For most prospective parents, a puppy is not an acceptable substitute for a baby" (Krawiec 2010, 45).

Slavery

Parents do not like to view surrogacy, or other fertility treatments, as a market transaction. People do not like market language and economic principles applied to human beings. This is because people do not like the images of slavery conjured up when supply, demand and the market are applied to babies and women's bodies. Many people consider slavery to be the darkest part of U.S. history. This has heavily influenced the laws that prohibit baby selling, the same laws that inhibited surrogacy before the success of IVF. According to Michele Goodwin, the

baby market began with slave owners who sold their biological children, conceived by slaves, into slavery. This was a sad yet common practice in the U.S. Even Thomas Jefferson, a Founding Father, was in all likelihood the father of the enslaved mulatto children of his slave mistress Sally Hemings. It was common practice at the time for slave owners to sell the biracial children they fathered at markets, where prices were haggled and children were inspected as cattle. Frighteningly, just like with egg donors, good traits received higher prices. It is no wonder that comparing the contemporary baby market to slavery "reminds us of how slippery parentage can be and the awkwardness of applying market language to human beings and human relationships" (Goodwin 2010, xii). It also makes us question how differently we really perceive the concepts of ownership, usually the result of a purchase, compared to legal custody. This conflicts with our modern ideals of independent personhood and liberty (Goodwin, 2010).

Slavery was certainly not the end of placing value on children. Throughout history families have considered the economic value of their children, weighing their potential economic assets as wage earners, field or household help, and marriage potential against the costs of raising a child. If a son was considered more valuable because he could work, and a daughter a cost because of her future dowry, unwanted children could be shed through infanticide or abandonment. Of course not all families went to these measures in the U.S., but children were nonetheless considered for their economic purposes. It was not harmful to choose to have a large family in order to have more help on the farm. Economics have always played a role in having children.

Protecting Reproductive Freedom

Having surrogacy as part of the free market is not necessarily bad. In the U.S., people believe in free market economics because it avoids government control over people's personal decisions and pursues efficiency and profit maximization. Martha Ertman believes that leaving ARTs to self regulate in the free market is a good idea because state and federal legislation would allow the government to decide who could have children. This could leave minority groups such as same sex couples or single people without access to ARTs. The free market prioritizes liberty and innovation over tradition and divine or biological mandate. By allowing the free market regulation of surrogacy, we embrace American norms of consent, equality and a liberal commitment to freedom of action. According to the freedom to contract, surrogacy and other forms of ART should be allowed. Prohibition would deny the reproductive right to those who need surrogacy, would place the government into our most private interactions, and force surrogacy into the black market (Ertman 2010).

Debora Spar believes that the free market is the right place for ARTs because "the very impersonality of markets and sheer lack of normative content might actually make them uniquely capable of protecting reproductive freedoms" (Spar 2010, 177). She believes that the market is fundamentally neutral, only responding to our demands. Reproduction is a private good with unlimited resources. A demand or desire for children is harmless, and should thus mostly self regulate. Spar does recognize that the market, particularly with surrogacy, does need some regulation though because of its potential to exploit other parties involved, capable of

compelling women to sell their bodies and genetic material out of economic need. Historically, the free market has proven to protect reproductive freedoms and allow more access, and prohibition has proven ineffective in the cases of contraceptives, the birth control pill and IVF (Spar 2010).

In the U.S. contraception was a flourishing industry until 1873, when Anthony Comstock convinced Congress to pass the Act of Suppression of Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use. This Act grouped contraceptives with other 'obscene' items, outlawing their interstate transportation, their importation, and contraceptives and related materials' distribution through the post. Most states followed suit, instating their own additional Comstock laws, basically making birth control, its advertisement and information all illegal. These laws prohibited doctors from prescribing birth control and made any regulation impossible as the industry was driven underground. In 1938 there were almost 400 contraceptive options with a black market industry generating roughly $250 million annually. By prohibiting contraceptives, the government essentially promoted the high priced, ineffective bootleg contraceptive industry. After years of fighting for women's right to prevent conception, in 1936 in United States v. One Package, the Court ruled that doctors could again legally import and prescribe birth control (Spar 2010).

Work on the birth control pill began in 1937 when the potential of progesterone to prevent ovulation was recognized. However, due to the Comstock law still in place, labs did not attempt to bring their findings into the market. Not until the 1950's did Gregory Pincus begin experimenting with progesterone as

contraceptive under the private funding of Katherine Dexter McCormick. Mrs. McCormick was determined to give women a way to control their own reproduction. With the help of John Rock (who developed the first steps of IVF), they tested progesterone's ability to prevent conception by stopping ovulation, masking their research as infertility treatment. They tested their new birth control pill in Puerto Rico and Haiti, which was approved by the FDA as a treatment for gynecological disorders in 1957. In 1960 the pill was officially approved as a contraceptive, but roughly five hundred thousand women were already using the pill for its possible contraceptive side effect. This made supply and demand soar, and prices drop. In 1961, about 1 million women used the pill and the price dropped from $10 to $7 a month. By 1963, the price already fell to $2.90 per month for 1.75 million users. By 1973 an estimated 10 million women used the birth control pill (Spar 2010).

In 1974, a temporary moratorium was placed on the use of federal funds for fetal research. Though the first IVF baby was not born until 1978 in England, Congress was concerned with what would happen to aborted fetuses because the Supreme Court had just legalized abortions. After Louise Brown's birth however, there was a serge in demand for IVF in the U.S. This led Drs. Howard and Georgeanna Jones to open the first private U.S. IVF clinic in Norfolk, Virginia. When Elizabeth Jordan Carr, the first U.S. test-tube baby was born in 1981, there were only four other private IVF clinics in the U.S. Demand grew even though the price was still very high and success rates low. In 1983, a roughly 50% chance of having a baby using IVF cost around $38,000. By 1986, more than two thousand babies had been born using IVF in the U.S. and there were more than 100 clinics, generating

annual revenues of about forty-one million dollars. By 2003, IVF and related technologies in the U.S. generated over three billion dollars annually; there were 437 clinics and 48,756 babies produced (Spar 2010).

In all of these cases, government prohibition and tight regulation prevented people from having access to what we now consider standard reproductive technologies. Prohibiting contraceptives and delaying the development of the birth control pill hindered reproductive freedoms. Prohibition clearly proved ineffective and probably dangerous by forcing demand for contraceptives to be met by the black market supply. The pill and IVF both required private funding in the U.S. for their full development. In all of these cases, the free market brought benefits to the consumers and helped them earn reproductive freedom. Similarly with surrogacy, prohibition would not stop the practice; it would simply move underground or force hopeful parents to make contracts in different states or countries.

THE FREEMARKET'S SHORTCOMINGS

In these three cases, the free market did protect the consumers. However, surrogacy is fundamentally different from contraceptives, the pill and IVF. Surrogacy involves parties other than the consumers, the hopeful parents. With the contracting parents protected by the free market, surrogates, gamete donors and babies are left unprotected. Surrogate and gamete donors are susceptible to exploitation due to economic need. They are in danger of being coerced into selling their bodies and genetic material, things they may have otherwise never sold, due to their economic need. This is evident in the typically much lower economic and social statuses of egg donors and particularly surrogates than the contracting parents.

Their bodies are commodified, made into products purchasable at the right price. Children are also at risk of commodification. When the parents buy gametes with the most desirable traits for their future children, it is not all that different from early U.S. slave owners, buying slaves based on their physical traits and temperaments. Though there is clearly a different intent, it is still a similar practice. Many also fear the eugenic possibilities of parents choosing traits of their children. This is a fear Germany takes very seriously, and is a large influence on the Embryo Protection Act.

However, laws in the U.S. are mostly concerned with the rights of the consumer. This is a result of the American ideals of liberty and freedom, part of the ever-evolving liberal tradition, as I addressed earlier. The liberal tradition drives Americans to seek liberation from externally imposed social identities and the fulfillment of an inner plan. In America, people believe they should be free to be the person they want to be, and express him or herself as they please. This freedom of self has grown through the sexual revolution and the more recent push for gay marriage. This would change marriage from a confining institution into an individual right and personal choice. With reproductive technologies, people are now able to form their own families of choice, with no one saying who can and cannot make a family. However positive and progressive it may be, this freedom of personal development and fulfillment strikes a point of tension in the liberation of the child as an individual versus the adults' rights to form a family however they choose (Gallagher 2010). In Germany, this is a similar controversy, with the basic right to full development of personality being granted to fetuses and adults alike. In

the U.S. however, a fetus has no Constitutional status, so the parent's rights to procreate as they wish wins out in the end.

The other troubling aspect of the free market control of surrogacy is that it legitimizes the priority of the wealthy. It is a similar case with health care in the U.S., where people have a fundamental fear of government involvement in anything as personal as medicine. Physicians prefer autonomy because they can self regulate, as do fertility clinics. This, however, allows both to be transformed into for-profit institutions, where equal access is largely based on independent wealth. In the U.S. we do have outstanding medical facilities, innovative treatments and medications brought about by the free market, for those who can afford health insurance and the deductibles. People are not denied access based on race or sexual orientation, something Ertman fears could happen to ARTs under government regulation. In our current medical system, a definite member of the free market, people do not have equal access to care because of the outrageous costs. Similarly, if surrogacy is part of someone's reproductive right, then is it fair that only the wealthy have access?

It is not completely out of the question for legislation to pass regulating surrogacy in the U.S. There are regulatory systems in the medical field, which seem to be the closest model to fertility clinics. Spar suggests that "states could regulate [surrogacy], using traditional channels of authority to control the market or blunt its roughest edges", as they already do in other complex and intimate matters as adoption, marriage, medical research and organ transplants (Spar 2005, 305). It would not be un-American to impose some restrictions that would help protect the other parties involved in surrogacy, namely the surrogates, gamete donors and

children, who are left susceptible to harm under the free market regulation alone. It could actually help promote freedom for all, not just the direct consumers.

In conclusion, I believe that the United States has avoided national legislation of surrogacy as a result of the liberal tradition, allowing the free market to support liberty, equality and efficiency. Though it may be uncomfortable to apply economic terminology to humans and reproduction, previous attempts to remove contraceptives and birth control from the free market have proven harmful and ineffective. Some may argue that the lesson to be learned from that history is to leave surrogacy to the free market, because regulation has limited reproductive freedom, so the current model is the best available. I, however, believe that surrogacy is fundamentally different from other ARTs. The free market protects the consumers, but surrogacy arrangements involve additional parties who are not the consumers, left unprotected by the free market. The U.S. model of limited state by state legislation regarding surrogacy is flawed, and should be replaced by national legislation in order to protect all of the parties involved.

CHAPTER 5:

Context of German Policy

Germany became the first country to ban surrogacy due to the national feeling of hesitance toward genetic and reproductive control. This is a direct result of Germany's dark history of Nazi eugenics, which also influenced Germany's heavily debated abortion policy. German debate also aims to look at technology's impact on society on the whole, prioritizing the nature of a good society above individual benefits. Religious influence, particularly the Catholic framework of recognizing the fetus as being alive, along with a strong influence of feminist groups and the Greens, have all contributed to Germany's attempt to protect the rights of both mothers and the fetuses. Together these values have led to a different understanding of what are acceptable lengths to take in order to make a family. That is why egg donation and surrogacy are prohibited according to the Embryo Protection Act since 1991, limitations that would likely be found to be unconstitutional in the U.S.

NAZI HISTORY

The criticism of genetic engineering through gamete selection as a new form of eugenics is taken very seriously in Germany. Germans also take slippery slope arguments in this area seriously, in order to avoid possible expanded uses of genetic and reproductive technologies. This fear results from Nazi practices, based on the U.S.'s eugenic sterilization practices of forced sterilization of the mentally ill, the deformed and the supposedly socially unfit, made legal in Buck v. Bell in 1927. The Nazis expanded the practice of forced sterilization so broadly that genocide was qualified under eugenic goals. Jews, Gypsies, homosexuals, political radicals and

others who did not fit into the Nazi's Aryan ideal were all exterminated under the pretense of cleaning the German gene pool to achieve a perfect race. Nazi experimentations on human subjects were examples of medical torture, often resulting in disability, disfigurement or death of the subject. These crimes led to the creation of the Nuremberg Code for human experimentation.

With such a cruel and frightening history of genetic science, coupled with Germany's post-holocaust imperative of "Never Again", it is no surprise that German society has "a deep aversion… to the use of genetic science to classify and extend rights to people and thus to reproductive and medical technologies that control the earliest stages of human life" (Robertson 2004, 4). Seeing sterilization transition into an even darker practice of mass euthanasia makes Germans recognize the subjectivity of drawing a line to classify human rights abuse. Current German law thus strives for "recognizing the dignity of every person and granting each an equal place of honor in society" (Robertson 2004, 3).

Germany's abortion law is a clear reaction to the Nazi regime. What were previously liberal abortion and birth control laws in Germany, were then tightened and strictly enforced in accordance with eugenic criteria. Because German women were supposed to repopulate the world with the Aryan race, abortions and birth control were prohibited. After WWII, Germany was divided and both East and West Germany reacted against Nazi crimes. East Germany legalized abortion upon request in 1972. In West Germany, feminist groups achieved liberalization of abortion laws in 1974, but abortion was quickly restricted again. The Federal Constitutional Court found that the liberal abortion laws conflicted with the fetuses'

constitutionally protected right to life and the state's duty to protect human dignity. "The state's obligation to see pregnancy carried to term was justified by the recollection of Nazi crimes" (Hashiloni-Dolev and Weiner 2008, 1056). West Germany compared East Germany's lax abortion regulation with Nazi genocidal practices. Interestingly, as a reaction to the Nazi's disrespect for human life, West Germany prohibited abortions, just as the Nazis had, again limiting women's reproductive freedom.

When East and West Germany were reunited in 1990, the two conflicting abortion laws resulted in a great debate. In 1992, the German parliament's first solution was to legalize abortion on demand, under certain conditions, during the first trimester once counseling was received. The Federal Constitutional Court suspended the law because it was found to conflict with three fundamental rights: the protection of human dignity, the demand to guarantee free development of personality and the right to life (Hashiloni-Dolev and Weiner 2008). As a result, first trimester abortions were made illegal, but not prosecutable. In 1995, the 'Pregnancy Conflict Law' abolished the eugenic justification for abortion (abortion due to fetal medical condition), leaving only medical (abortion due to the mother's mental or physical condition) and criminal (abortion when rape or incest result in pregnancy) justifications for abortion.

Today, these laws mean that although abortion is unlawful, first trimester abortions are accessible and unpunishable after the woman receives counseling that stresses the fetal right to life, and a waiting period of a few days after counseling. Late term abortions are also permitted under some circumstances, but are harder to

obtain as most genetic counselors morally object (Hashiloni-Dolev and Weiner 2008). Germany realized that criminalizing abortion only causes women to seek illegal abortions, where they would avoid counseling that could possibly change their mind. Though private insurers are prohibited from covering elective abortions, the state recognizes its obligation to pay for abortions for those in need, a position which in action has the state pay for the majority of all abortions (Robertson 2004).

The Nazi past has permeated the discourse of all reproductive technologies in Germany. In his 2001 Berlin Address, then President of State, Johannes Rau, reminded Germans never to forget the sins of their past in the biogenetic future (Brown 2004). An even more overt tie between Nazis and cloning was made in an editorial, published in the German national daily newspaper, *Die Welt*. The article claimed, "the cloning of human beings would fit precisely into Adolf Hitler's world views. And there is no doubt that he would have used this technology intensively if it were available at the time. Thank God it wasn't" (Brown 2004).

THE GOOD SOCIETY

In 1979, Hans Jonas published *The Imperative of Responsibility: In Search of Ethics for the Technological Age*, and it was a best seller in Germany. Throughout, Jonas argues that the new powers granted to us through modern technology make necessary a revolution in man's idea of "ethical responsibility" (Brown 2004). He fears that technology could run beyond our control and threaten human and non-human life in the future. Though he is concerned with the dangers of nuclear weapons, new genetics are his real fear. To avoid such a future, Jonas recommends setting limits on technology today, before it is unstoppable. In the years after Jonas'

publication, various social justice movements regarding nuclear technology, genetic engineering, the environment, health care, and the rights of women, minorities and the disabled, bound together by their common aversion to man's domination over nature, believing that a technological ethos would put humanity on the whole at risk (Brown 2004). As a result of the public discourse, by 1984, a large number of Greens were elected to parliament, influencing the agenda of the Bundestag, setting the stage for the Embryo Protection Act.

Louis Hartz, in *The Liberal Tradition in America*, regarding a history of feudalism asks whether a people "born equal" can "ever understand peoples elsewhere that have to become so? Can [such a people] ever understand itself?" (Hartz, 1955). I think this relates directly to the focus on the good of society on the whole in Germany. After the fall of the Nazis, Germany had to make all people equal again. To continue to ensure this equality, legal and ethical debates focus on "the nature of the good society, not exclusively about balancing risks and benefits or about individual rights" (Braun 2005, 44). The "common ethos… at the heart of the polity" is found through public debate with the citizens (Braun 2005, 44).

One such example is the one-week symposium convened in 2000 by Minister of Health and Greens member, Andrea Fischer, on human genetics and reproductive medicine. The symposium was called in response the debate over the ban of PGD under the Embryo Protection Act, and the proposed guidelines to soften the law. At the symposium, participants largely agreed that medical technology should not be judged from an individual perspective, but rather from its impact on society's basic values. They reinforced that the social and cultural context of fertility problems

must be taken seriously, focusing on the pre-conditions and potential non-technological solutions. The priority of ethics in political debate was reinforced at a 2001 Bundestag general debate on bioethics and biomedicine when parliamentarians "stressed [that] 'big issues,' such as that of biomedicine should never be delegated to science or expert bodies" (Braun 2005, 46).

THE RIGHT TO LIFE

Germany's stance on reproductive technologies is also largely affected by the Catholic perception of life beginning at conception. Though Catholics make up only one-third of the German population, abortion is not a major issue of conflict for Protestants, leading to diverse positions. Because Catholic doctrine frames their side of the abortion debate as the 'right to life', opponents are forced to debate using Catholic terms of discourse. Even legal discussion cannot avoid the framework created by Catholic doctrine. As a result, fetuses and embryos are formally protected by law, and they receive the same rights to life and dignity as all people. Also in accordance with Catholic beliefs, there is a strong distinction between the mother and the fetus. Because the mother is constitutionally granted free development of personality, laws regulating reproduction fight to balance her rights with the fetus' right to life; one does not trump the other. This is why Germany can distinguish between the illegality and criminality of abortion, protecting both the fetus' right to life and the mother's free development of personality simultaneously (Hashiloni-Dolev and Weiner 2008).

The role of feminist groups and the Greens party in Germany has also contributed to Germany's abolition of surrogacy and egg donation. The Greens party

in Germany (Alliance '90) holds roughly 10% of the seats in parliament. Greens and many feminist groups oppose the power of impersonal technologies, and are also heavily influenced by the Nazi history. They have joined pro-life movements in framing genetic screening issues into the human rights framework. Though these groups do want to protect women's rights in terms of abortions, they emphasize "the need to balance these rights with the right to life of fetuses and embryos" (Robertson 2004, 4). Greens and feminist groups fought for the Embryo Protection Act and particularly the prohibition of surrogacy, and many find the Act still too lenient. The Greens object to the allowance of embryo selection in cases of severe hereditary disorders. According to the Green party "for the first time since 1945… Germany has a law to name specific disorders as justification for selective measures against human life" (Karchler 1990). They consider all IVF procedures to be unethical experimentation on human life.

Feminist groups have actively opposed surrogacy as well as other reproductive technologies as control and commodification of women's bodies and reproduction. In 1988, feminist groups worked together to shut down a branch of American Noel Keane's surrogate business, United Family International, in Frankfurt, only three months after it opened. They campaigned "to stop the sale of American women to European men for breeding purposes", and supported the efforts of the U.S. group, the National Coalition Against Surrogacy, to ban surrogacy in the U.S. (Corea 1988). German feminists groups argue that reproductive and genetic technologies are a "weapon of social control" and play a "role in the world marketing strategies of multinational corporations" (Corea 1988). The influence of

these groups is evident in the expanded criticism of reproductive technologies by trade unions, church groups and political parties.

POSIBILITY OF CHANGE?

In 2000, Chancellor Gerhard Schröder established the *Nationaler Ethikrat* (the National Council of Ethics) as a managerial counterpart to the dominant republican discourse in Germany. Schröder hoped that the council would help German policy move away from complete bans, particularly in the embryonic stem cell research debate. He argued that the future benefits from embryonic stem cell research must be balanced against any ethical responsibilities to ban it. His focus however, was on the fear of losing medical research to the United States (Braun 2005). The council intends to address "areas of tension between great medical hopes, economic expectations, and people's understandable fears of reproduction and selection" (Brown 2004, 39).

In the 2001 stem cell debate, Germany's two most important Social Democrats pitted against each other, Chancellor Schröder and President Rau. The debate highlighted how in Germany, techno-optimism and techno-skepticism cross both liberal and conservative party lines. Schröder argued, that without biotechnology, "we will hardly be able to secure our prosperity for our children and grandchildren" (Brown 2004, 47). He emphasized that "the ethics of healing" require equal attention as "the ethics of creation" (Brown 2004, 47). In opposition, Rau reminded Germans of the Nazi past, stating that, "No one should forget what happened in the academic and research fields during that period…. An uncontrolled

scientific community researched for the sake of its scientific aims without any moral scruples" (Brown 2004, 47).

From the debate, a compromise was reached. As a result, German scientists can now import stem cells only if they were harvested before 2001 and if the biomedical research is of "overwhelming significance". This was not the last compromise of the Embryo Protection Act. In the December 2003 U.N. General Assembly, the U.S. and 50 other countries supported a total ban on human cloning, including the production of cloned embryos for research. Germany, however, along with Great Britain, France, Russia and China, favored an international ban on reproductive cloning, but also believed that individual countries should be allowed to make their own laws regarding cloning of embryos for research. This stance can be seen as a possible effort to revise German domestic policy regarding cloning from the outside, or an effort to normalize, and take a more moderate stance like other European countries. Even Minister of Health and Green Party member, Andrea Fischer stated, "It is not possible to be completely for or against biotechnology… Things have changed and that is reality. You can't be against reality" (Brown 2004, 47). However, now nearly ten years later, there has been no further reform regarding reproductive technologies.

In Germany, the Nazi history of human rights abuse through genetic science, in combination with the Catholic view of the fetus as being alive from conception, have greatly influenced German policy. Surrogacy and egg donation are thought to cross the line in terms of what is acceptable to buy in order to create a family.

Buying a child from a traditional surrogate, buying the body of a gestational surrogate, and buying the genetic make up of an egg donor are all seen as violations to women's rights. The potential of eugenic goals in gamete selection are also viewed as being too similar to Nazi genetic practices. However, there is no clear reason why sperm donation is allowed, and yet egg donation is not. The Embryo Protection Act may be too restrictive. However, there is still room for change in Germany. The ban on surrogacy and egg donation may be seen as a violation of women's right to reproduce, as it places undue burden on women who are unable to produce viable eggs or gestate a child. Also, the limitations on embryo research may be found to be in contradiction to the constitutionally protected freedom of research. As we have seen, changes have already been made, allowing more leniency in PGD and opening a possibility for cloning for research. However, these laws cannot be changed until a plaintiff brings their argument before a judge.

CHAPTER 6:

Policy Proposal

I believe there is a middle ground between the lack of surrogacy regulation in the United States and total prohibition in Germany. I think a more moderate model, in which surrogacy is allowed, but heavily regulated, would promote reproductive freedom while simultaneously protecting the parties generally exploited by the free market approach alone. I believe that surrogacy can continue as a market in our economic system, but that a regulatory system should license and monitor fertility clinics and establish guidelines that will maximize reproductive freedom while protecting the surrogates, egg donors and commissioned children from exploitation. Strict guidelines would also help minimize court cases with legal disputes, ultimately protecting the intentions of every party involved.

REGULATORY SYSTEM

An official regulatory system that licenses fertility clinics, sets guidelines for ARTs, and makes certain that clinics obey the guidelines, needs to be created. This could be modeled after the system in the U.K., where the Human Fertilization and Embryology Authority ("HFEA") was established as the independent central regulatory authority for fertility treatments and embryo research in 1990. In the U.K. a clinic must be licensed by HFEA to provide assisted reproduction. Neither the U.S. nor Germany has any such licensing requirement. HFEA has the authority to set ARTs practice policies in accordance with parliamentary decisions and collect data on results (Robertson 2004). I believe a regulatory system similar to HFEA would still allow fertility clinics freedom by avoiding direct government regulation and

bureaucracy, and allowing the guidelines and regulations to be set by medical professionals. A regulatory system would also protect patients, including the intended parents, surrogates and gamete donors, by ensuring that the clinic abides by the guidelines. This would make sure guidelines are applied before and during treatments, not just after the fact to determine the legal custody of the child in cases of legal dispute. Guidelines would be set in order to protect all the parties involved and thus minimize legal uncertainty and dispute.

PROHIBIT TRADITIONAL SURROGACY

I believe that the regulatory system should set guidelines similar to the surrogacy regulation in the state of Illinois. The first of the restrictions would prohibit traditional surrogacy. I believe that even with regulation of traditional surrogacy, such as giving the surrogate 48 hours after the birth to reclaim her biological child, traditional surrogacy is almost indistinguishable from selling ones own children. To pay a woman to gestate and birth her own child, only to relinquish it to whomever commissioned the child, turns women's bodies into a commodity more so than with gestational surrogacy. I believe this is because the traditional surrogate sells herself along with her services. She sells her genetic make up, and she must forgo any prenatal bonding and connection she feels for her own genetic child in order to fulfill a contract. Economic pressure may force women to sell what they otherwise would not. Even if she is given time to change her mind and not fulfill the contract, she may feel pressure to do so, despite her emotional bond in order to receive payment. Traditional surrogacy contracts are also dangerous for contracting parents, because they may risk losing their child to the biological mother after

months of emotional and financial investment. Traditional surrogacy is too similar to baby selling and has too many complications. There is no reason why traditional surrogacy should be allowed when gestational surrogacy is a better alternative.

PARENTAL RESTRICTIONS

Gestational surrogacy, however, still requires regulation. The regulatory system should require the child to be conceived using gametes from at least one of the contracting parents, as is required in the state of Illinois (Center for American Progress 2007). Currently, only five percent of surrogacy arrangements do not use gametes from at least one of the contracting parents. Though this is a small percentage, these cases have the most legal disputes. This may seem like a significant restriction, but I believe the small number of people who would be inconvenienced by this rule still have the option of adoption. I believe that parents should be required to prove that they need the services of surrogacy in order to use it. Mothers must have medical proof that they either do not have viable eggs or that they are medically unable to gestate or birth a child. Surrogacy should not be used as a tool of vanity for women who do not wish to have their bodies or social lives altered by pregnancy. Such selfish priorities are not compatible with the true desire to have a child. If the intending mother is unable to gestate the child for whatever reason, but the intending parents still desire to have some genetic link, then this is the appropriate use of surrogacy. I do not understand why commissioning the birth of a child using surrogacy, donor egg and donor sperm is necessary when adopting a child achieves the same ultimate goal, especially since there are so many children around the world in need of families.

With a genetic link to at least one of the contracting parents, the child is also protected. At least one parent is guaranteed to have legal responsibility for the child once it is born. There have been a number of cases in the U.S. in which children have been left unclaimed because of the contracting parents' divorce, and the child has been conceived using donor egg and sperm. Requiring a genetic link ensures that the child has a legal guardian upon its birth no matter what disputes arise. This would also simplify custody issues after the child was born because no adoption will be necessary. The intended parents should be named the legal parents upon the child's birth, even if it is only genetically related to one parent. Some people fear that regulation of ARTs would limit its accessibility to minority groups. I, however, think that the regulatory system should apply rules for fertility clinics to protect of same sex couples, unmarried couples and single people to the same extent as applied to married heterosexual couples. Fertility clinics should not be allowed to discriminate against people based on prejudices.

PSYCHOLOGICAL SCREENING

This does not mean that just anyone should have access to surrogacy. The contracting parents, even though they will have a genetic link, must undergo psychological screening, as must the surrogate. This will ensure that all parties involved are well intended and that they understand what surrogacy actually entails. Though a psychological examination is obviously not required to have a child traditionally, and requiring one would be a violation of reproductive rights, utilizing the services of a fertility clinic and contracting the birth of a child makes surrogacy fundamentally different from traditional birth. I view surrogacy more

akin to adoption than to traditional birth. I strongly believe that fertility clinics should be held partly responsible if a child is placed into dangerous hands. One's reproductive right is not an all encompassing right; no one can be prevented from having a child, but all possible lengths do not have to be taken in order to place a child in the hands of anyone who so desires.

A psychological screening of the intended parents will ensure that the intended mother understands that she may feel jealous of the gestational surrogate's prenatal bond with the child, and the intended father is not spiteful that he may not be genetically related. The surrogate must undergo a psychological screening as well to ensure that she is prepared to give the child up after it is born, and that she will properly care for the child during pregnancy. The information from the psychological screenings should be disclosed to all parties involved in the contract. The surrogate must agree to carry the child for the parents knowing that one has a history of depression, or that they are divorced, or that they already have five children, etc. The purpose of the information disclosure is so that neither the surrogate nor the parents sign a contract that they otherwise would not. Guidelines would be set by the regulatory system, but the contracting parents and the surrogate would make the ultimate final decision. This also prevents the fertility clinics from making moral judgment calls on whom they will treat, except in extreme circumstances, of course.

SURROGATE RESTRICTIONS

In addition to the psychological screening, the surrogate must prove that she has previously given birth. This way she understands the significance of the prenatal

bond, and helps limit the possibility of medical complications during pregnancy and birth. The surrogate must also be at least twenty-one years old. In order to minimize the possibility of exploitation for economic need, financial compensation should be limited. The payment to surrogates should cover medical expenses and proper care during pregnancy. The surrogate should make some, though minimal profit, from the exchange. Both the surrogate and the intended parents should receive independent legal consultation before conception. This will ensure that everyone's needs are met by the contract. The surrogate should be given twelve months after the birth of the child to challenge the contract. This gives the surrogate rights to the child in case the parents do not follow through with their end of the contract or the surrogate feels that the parents do not provide a suitable home for the child. It would be unfair to the surrogate to relinquish permanently all rights to the child she gestated for nine months, formed an emotional bond with, and brought into the world. She does, after all, enter into the contract before the child is even conceived. Expectations and relationships may change during nine months of pregnancy. She may have developed a real relationship with the child by the time it is born, even if it is not her biological child. This is opposed to the conceptual relationship with the future child when the contract was signed. I believe this justifies the surrogate's option to challenge the contract given the fact that her relationship with the child is fundamentally different at the time of signing than when it is time to follow through and turn over the child. In case of legal dispute, the court should make its decisions based on the best interest of the child and the parties' intent.

AIMED TO PROTECT

These guidelines are all aimed to limit legal disputes and protect all of the parties involved. With these regulations, there will be fewer legal disputes because the child will be guaranteed a legal guardian due to the genetic link to one parent. Prohibiting traditional surrogacy also prevents the possible custody dispute between the surrogate and the intended parents, each having a genetic link to the child, complicating court decisions. Disclosure of information from psychological screenings of the parents and the surrogate will also help ensure that the child will be placed into a safe home and that the surrogate is comfortable relinquishing custody to the parents after she gives birth. The contracting parents will also be protected because all types of family forms will be welcome, including same-sex couples and single people, all treated equally as the traditional married heterosexual couple. The parents will also have more legal clarity if clear national guidelines exist, because there is less room for legal dispute when they have a genetic link to the child. The surrogate will be protected by lessening commodification of her body through traditional surrogacy, where she sells herself along with her services. Regulation, not prohibition, allows the surrogate the most personal freedom and protection by minimizing chances of exploitation while still allowing her freedom to contract and to receive money for her services. Surrogates will not be held to an irrevocable contract by allowing surrogates to challenge the contract up to twelve months after giving birth. The child will also be protected by ensuring that it has legal guardians upon its birth and that it is not placed into unsuited hands. The child will be less commodified because it will not be built from discriminatory gamete

selection akin to eugenics. Rather gamete donation will be used when needed, not just when purchased to produce a specific type of child.

I believe that this form of regulation will make surrogacy as safe and accessible as possible to all parties involved. The free market will continue to pursue innovation and efficiency, maximizing consumer liberties, but a regulatory system enforcing guidelines will prevent the exploitation of the other parties involved in surrogacy contracts. With national guidelines enforced by an independent authorized agency, government involvement will be kept at a minimum and medical professionals can control their own field. The unanimity of national guidelines opens up surrogacy contracts across state lines with ease, allowing clarity on legal and contractual issues impacting the clinics, the parents and the surrogates. I think such a system is possible in both the U.S. and Germany, and would be a significant improvement from their current regulatory models.

CONCLUSION

"Technology... is a queer thing. It brings you great gifts with one hand, and it stabs you in the back with the other."

-Carrie P. Snow, *Comedian*

Surrogacy is a triumph of technology, both fulfilling the needs of people unable to gestate and birth a child on their own, and creating a market for women to act as egg donors or surrogates. Now, women with medical conditions and same sex couples can have genetically related children, broadening our societal conception of what constitutes a traditional family. Enabling women to benefit from their reproductive ability by acting as an egg donor or surrogate also expands women's agency by allowing her any form of work she chooses, and reinforces the distinction between the child bearing and child rearing roles.

However, along with these benefits come a number of complications. In this thesis I have brought attention to a number questions that arise from the ethical debate. For example, just how far does our right to procreate extend: should anyone be allowed a child if they can pay for it? Does enforcing a surrogacy contract, making the surrogate forgo any rights to the child she gestated, fall under her right to contract and thus show her legal competence and rationale? Or does it infringe on her rights to the child, forcing her to alienate herself from her womb and the fetus, even potentially exploiting her economic need? When paying for surrogacy, what exactly is being bought, the surrogate's body, her services, or the child itself? None of these questions have clear objective answers, and as I have shown, the United

States and Germany are examples of two countries prioritizing different parts of the ethical debate.

In the United States, I have argued that opting for free market regulation of ARTs prioritizes the rights of the potential parents. Though a number of states have legislation regarding surrogacy, there is still no regulatory system to enforce the laws until there is a civil dispute. Additionally, the range of laws complicate surrogacy arrangements that cross state lines, as they very often do. As a result, there are frequent custody battles between surrogates and the intended parents, causing heartache for both parties as well as the newborn. In Germany, on the other hand, surrogacy is completely banned under the Embryo Protection Act. This is part of a movement in Germany to protect the embryo as the initial form of human life, and partly in reaction to surrogacy in the U.S., hoping to avoid the complications and legal disputes. I believe that neither of these methods are the best way to regulate surrogacy.

In this thesis, I have focused my attention on the historical, economic and social contexts that have lead to the differing policies. Though this is a lofty goal, I have tried to focus on some of the most significant differences and what I find to be particularly influential. In the United States, the liberal tradition prioritizes individual liberty and equality, entrusting their protection to the free market. Free market regulation has proven itself effective in the examples of contraceptives, the birth control pill and IVF, all of which were stifled and access to limited by government regulation. In these cases, the free market promotes freedom, efficiency and equal access. Surrogacy is different though, because not only do the customers

require protection, but the surrogates, donors and children do as well. In Germany, the Nazi history has led to an aversion to reproductive and genetic sciences with any eugenic implications. The Nazi past has influenced the discourse on all reproductive technologies, using the Catholic framework considering the fetus to be alive. German law strives to balance the rights of the fetus and the rights of the parents, but emphasizes the position for the good of society on the whole. With strong Green and feminist political influence, Germany believes that by deliberately limiting reproductive technologies, they are exhibiting collective self-determination to do what is ethically and morally right.

In criticizing these two models as being too extreme, I found it only fair to suggest my own model for regulating surrogacy. Though by no means do I think my model is exhaustive, I believe it shows that there are alternatives to deregulation and total prohibition. I have suggested a model in which traditional surrogacy is prohibited because it is too akin to baby-selling. Gestational surrogacy is heavily regulated in order to protect the rights of the contracting parents, the surrogates and the children born. I believe that total prohibition limits the freedoms of those who could benefit from the technology and marks something as "evil" even when this may not be the case. Additionally, prohibition leads to black market alternatives and, as I have chosen to exclude from my thesis, international surrogacy arrangements. This is a topic too large to be discussed here, as it intensifies the issues that arise in domestic surrogacy arrangements and brings about new problems related to globalization and race. I only mention it here to emphasize that prohibition does not stop a "morally wrong" practice; it only pushes it into someone

else's territory. The goal of my more moderate surrogacy regulatory model, which I believe to be well suited for both the United States and Germany, is to protect reproductive freedoms and allow reproductive technology to strive for good.

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